Eligibility for Individuals and Families

Participant Guide

Version 1.0

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1 ELIGIBILITY FOR INDIVIDUALS AND FAMILIES

In the Eligibility for Individuals and Families course, we take an in-depth look at the consumer application pathway and individual eligibility requirements for Insurance Affordability Programs including Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California Health Plans, with and without premium assistance. The Eligibility for Individuals and Families course also reviews the verification process when validating eligibility for health insurance and the time frames for applying for coverage including Open Enrollment and Special Enrollment periods. Eligibility for and the use of premium assistance and cost-sharing reductions are also covered. Finally, the Eligibility for Individuals and Families course reviews the appeals process and consumer responsibilities.

1.1 LEARNING OBJECTIVES

At the end of this course, you will be able to explain:

- ✓ How and when the consumer can apply for coverage
- ✓ Open enrollment and when can individuals enroll
- ✓ Eligibility rules for MAGI Medi-Cal and Covered California Health Plans
- ✓ Minimum Essential Coverage (MEC) and the Covered California verification process
- ✓ Eligibility, verification and process for American Indians and Alaska Natives
- ✓ Appeals process available to consumers
- ✓ Responsibilities consumers have to report changes that may affect their eligibility

2 LESSON 1: OVERVIEW OF ELIGIBILITY

This lesson will cover details related to eligibility: how to apply for coverage through Covered California, how to navigate the application process, and understanding open enrollment periods.

2.1 LEARNING OBJECTIVES

By the end of this lesson, you will be able to:

- ✓ Describe how and when the consumer can apply for coverage
- ✓ Understand the application, sections and questions
- ✓ Define the eligibility system
- ✓ Describe key dates for open enrollment
- ✓ Describe special enrollment periods and qualifications

2.1.1 HOW TO APPLY FOR COVERAGE

The first step in obtaining coverage begins with the consumer completing a single streamlined application through Covered California. Consumers can apply in the way that works best for them including:

- Online at www.CoveredCA.com
- By phone via the Covered California Service center
- By U.S. Postal Mail
- In person with an individual certified by Covered California to perform enrollment assistance. These locations must have reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act

The application is made as easy as possible by only asking questions that are necessary for determining eligibility. The application will ask about:

- Number of household members, members who need health insurance, and the place of their residence
- Income of household members including salaries, wages and unearned income
- Citizenship/Immigration status of those applying
- Social Security Numbers (SSN): are used to verify income and citizenship status. SSNs will not be necessary for members who do not need health insurance, but may be helpful in verifying information for those applying. SSNs, therefore, may be provided by non-applicants if they wish to do so.
    - **Example 1**: A mother who is not seeking coverage and is applying on behalf of her child must provide her child's SSN but does not have to provide her own SSN.
    - **Example 2**: A mother is applying for coverage for one child and there is another child residing in the household, but does not need insurance. The mother only needs to provide the SSN for the child who needs coverage.

- A Rights and Responsibilities page must be signed by the applicant (or an authorized rep). By signing, the applicant agrees that the applicant has provided true and accurate information, understands their rights as an applicant, and agrees to other responsibilities.

2.1.2 Single, Streamlined Application

Covered California has a single, streamlined application to make it easy for eligible consumers to apply and enroll. The application is designed to both determine eligibility and collect the information necessary to:

- Enroll in MAGI Medi-Cal
- Purchase a Covered California Health Plan at full cost without premium assistance.
- Purchase a Covered California Health Plan and qualify for premium assistance and cost-sharing reductions

Good to Know

Certified Enrollment Counselors and Certified Insurance Agents will learn how to use online application through a separate training. The training goes through the single, streamlined application in detail and all the information consumers will need to provide in order to apply for health insurance and have their eligibility determined.

2.1.3 Application Sections and Questions

The Covered California application guides consumers through the eligibility process and determines all of their options. Consumers can complete applications themselves or work with a Certified Enrollment Counselor or Certified Insurance Agent.

Understanding the application and the information required is the key to submitting a complete and successful application.

Application Section	Questions (high-level summary)
Getting Started	• Whether or not the consumer is applying for subsidized coverage. • Assistance in filling out application (e.g., or Certified Enrollment Counselor or Certified Insurance Agent). • Whether or not the consumer is applying during a Special Enrollment Period • General questions regarding household size • How the consumer learned about Covered California • Consent to verification process
Primary Contact Information	Contact information including: • Name • Telephone numbers • Home mailing address • E-mail address

Application Section	Questions (high-level summary)
	Preferences for: • method of communication • written and spoken language
Additional Household Members	• Information about individuals living in the home and if they are applying for coverage • Name, date of birth, gender, U.S. citizen/national or lawfully present status if applying for coverage, Social Security Number if applying for coverage. • Relationship to the primary contact person • Contact information if different from the primary contact
Additional Household Member Demographic Data	• Marital status • Pregnancy status and, if pregnant, due date and number of babies expected • Member of a federally-recognized Indian tribe • Full-time student • Blind and/or disabled (for non-MAGI Medi-Cal eligibility determination • Medical expenses in the last three months (relevant if consumer requests retroactive Medi-Cal coverage) • In foster care at the age of 18
Additional Household Member Tax Information	• Tax filing status (e.g. Number of dependents claimed, head of household, filing taxes for upcoming year)
Applying members – Other healthcare information	• Employer-sponsored health insurance (to determine minimum standard value and affordability related to monthly premiums) • Long-term care needs (for non-MAGI Medi-Cal eligibility determination) • Medicare coverage
Applying members — referral to non-health services programs	• CalWorks • CalFresh
Optional Information	• Ethnicity
Income Information	• Income type/income source, amount and frequency
Income Summary	• Review of your current and projected annual income
Signature Page	• Rights and Responsibilities • Signature

2.1.4 Eligibility System

The online application is the single, streamlined eligibility and enrollment system for all products and programs available through Covered California. The online application is set up so that consumers input basic eligibility information. Then the online application shows the Covered California options that the applicants are eligible for.

As part of the application and eligibility determination process, consumers will learn if they are eligible for Medi-Cal, a Covered California plan at full cost or a Covered California plan with premium assistance or cost-sharing reductions.

2.1.5 When to Apply for Eligibility

Applicants who are eligible for Medi-Cal may apply for health insurance at any point throughout the year. The effective dates for their Medi-Cal will be the date of the application. Some individuals may also be eligible to have Medi-Cal pay medical bills up to three months prior to the date of their Medi-Cal application.

Applicants who are eligible for Covered California, both with or without premium assistance, can apply during Open Enrollment. Open enrollment is the period of time when consumers may select a health plan and enroll. Open enrollment usually happens once a year.

In addition, certain qualifying events allow consumers to apply for coverage during special enrollment periods. Covered California has both an annual open enrollment and special enrollment periods to make it easy for consumers to enroll in affordable, quality coverage.

2.1.6 Key Enrollment and Effective Dates for Covered California Plans

	Time Frame	Enrollment Date	Coverage Date
Initial Enrollment Period[i]	October 1st, 2013–March 31st, 2014 Note: The initial enrollment period is longer than subsequent annual open enrollment periods to give more time for consumers to learn about the options and enroll.	On or before December 15th, 2013	January 1st, 2014
		Between the 1st and 15th of the month	The first day of the following month. For example, coverage for a consumer who enrolls on January 10th will be effective February 1st.
		Between the 16th and last day of the month	The first day of the second following month. For example, coverage for a consumer who enrolls on January 17th will be effective March 1st.

	Time Frame	Enrollment Date	Coverage Date
Annual Enrollment Period[ii]	October 15th, 2014–December 7th, 2014 and every year thereafter.	January 1st of the next year.	

2.1.7 Special Enrollment Periods and Who Qualifies

A special enrollment period is a time outside of the open enrollment period during which consumers are eligible to sign up for health insurance.

Special Enrollment

Qualified individuals can enroll in a Covered California Health Plan or change their Covered California Health Plan when any of these events happen:

- A qualified individual or dependent loses Minimum Essential Coverage (MEC) (this is defined in greater detail below);
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual who was not previously a citizen, a national or a lawfully present individual gains such status which makes them newly eligible for coverage;
- A qualified individual's enrollment or non-enrollment in a Covered California Health Plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of anyone involved with Covered California or the Department of Health and Human Services;
- An enrollee adequately demonstrates to Covered California that the Covered California Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for premium assistance or has a change in eligibility for cost-sharing reductions, regardless of whether the individual is already enrolled in a Covered California Health Plan;
- An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value; and
- A qualified individual or enrollee gains access to Covered California Health Plans as a result of a permanent move.

Enrollment Date Based on Special Qualifying Event	Coverage Effective
1st and 15th of the month	First day of the following month
16th and last day of the month	First day of the second following month

Enrollment Date Based on Special Qualifying Event	Coverage Effective
Birth, adoption or placement of adoption	On the date of birth, adoption or placement for adoption. Note: any premium assistance and CSRs are effective the first day of the following month.
Marriage	First day of the following month
Loss of MEC	First day of the following month

2.1.8 Special Enrollment Circumstances

Federally recognized American Indians and Alaska Natives may enroll in or change existing coverage in Covered California Health Plans one time per month.

As previously mentioned individuals who are income eligible for Medi-Cal may apply at any time during the year and are not limited to Open Enrollment periods. When people have income changes that would qualify them for Medi-Cal, they can apply for Medi-Cal any time.

2.1.9 Application Processing Times

Covered California's goal is to connect consumers with health insurance as quickly and easily as possible. The processing timeframes vary by the way the application is submitted and whether or not it is complete or has inconsistencies.

Timeframe	Application Channel
Real-time, within minutes	Online and telephone applications that do not require resolution of any inconsistencies. Additional information to process the application and make a determination of eligibility.
10 calendar days	Complete paper applications received by mail or fax. Paper or faxed applications that require additional information because there are missing data elements.
Within 90 days	Consumers have 90 days to resolve an inconsistency between what eligibility information the applicant provided and information CALHEERS (online application) uses to verify the eligibility. Consumers will be conditionally eligible for premium assistance for a Covered California Health Plan when an application requires a resolution of an inconsistency based on income. Consumers will be conditionally eligible for Medi-Cal when an application requires resolution based on citizenship or immigration status.

3 LESSON 2: OVERVIEW OF MEDI-CAL AND COVERED CALIFORNIA HEALTH COVERAGE OPTIONS

3.1 LEARNING OBJECTIVES

By the end of this lesson, you will be able to:

- ✓ Describe Medi-Cal eligibility requirements
- ✓ Define Citizenship and Immigration Status requirements
- ✓ Define income eligibility
- ✓ Understand Non-MAGI eligibility
- ✓ Describe Medi-Cal term of eligibility and premium assistance

3.1.1 Covered California Coverage Options Overview

Making health insurance more affordable is a key priority of the Affordable Care Act, and one shared by Covered California. Covered California will play a critical role in helping low- and moderate-income individuals and families obtain Medi-Cal or federal advance premium assistance that will reduce the amount they spend on premiums.

Consumers will be determined eligible for one of three paths to health coverage through Covered California:

1. Medi-Cal; or
2. Covered California Health Plan without premium assistance; or
3. Covered California Health Plan with premium assistance, including CSR.

To determine which path of health coverage a consumer is eligible for, applicant's household income is compared against the Federal Poverty Level (FPL) for their household size. FPL is the minimum amount of gross income (before taxes) that a family needs for food, clothing, transportation, shelter and other necessities. The Department of Health and Human Services (HHS) determines the amount each year. The amount varies by family size and is adjusted for inflation.

Different income eligibility levels apply for Medi-Cal and for premium assistance for Covered California Health Plan coverage. The eligibility for each person applying for coverage is determined separately. It is important to note that members of the same family may be eligible for different health coverage. For example, a child could be eligible for Medi-Cal and his or her parents could be eligible for a Covered California Health Plan with premium assistance.

Covered California supports all consumers who need health insurance, regardless of the path for which they are eligible.

3.1.2 MEDI-CAL ELIGIBILITY OVERVIEW

Medi-Cal is California's version of the Medicaid program, paid for with federal and state taxes. This program provides health insurance to low-income California residents who meet certain requirements.

Also part of Medi-Cal is the Targeted Low-Income Children's Program (TLICP), formally known as Healthy Families. TLICP is a low-cost insurance program for children and teens that provides health, dental and vision coverage to children who do not have health insurance.

Expanding eligibility for Medi-Cal is one way the Affordable Care Act is increasing access to health insurance.

3.1.3 California Resident

In order to be eligible for Medi-Cal the applicant must reside, or intend to reside in California. Applicants will attest to their address on the single, streamlined application and the online application will accept that attestation as part of the verification process.

3.1.4 Citizenship and Immigration Status

To be eligible for Medi-Cal the applicant must be a citizen, a national or lawfully present in the U.S. with acceptable immigration status. Acceptable immigration status includes:

• Lawful Permanent Residents	• Conditional Entrants
• Refugees seeking asylum	• Cuban or Haitian Entrants
• Parolees	• Battered Aliens
• Aliens whose deportation is being withheld	• Alien Granted non-immigrant status

3.1.5 Income Eligibility

Modified Adjusted Gross Income: Three Step Evaluation Process

The ACA modified the way California will be calculating household income for determining Medi-Cal eligibility. The new methodology is called Modified Adjusted Gross Income (MAGI). The federal law changed the Medi-Cal income test to a MAGI income test in order to align the eligibility rules for all new health insurance options that are available to individuals.

For each individual who is applying for coverage and who fits into one of the four MAGI eligibility groups (children, adults, parents & caretaker relatives, and pregnant women), there are three steps that must be taken to determine whether an applicant is eligible for Medi-Cal based on MAGI:

STEP ONE: Identify the members of the applicant's family who are considered part of his or her household for MAGI Medi-Cal purposes.

STEP TWO: Add the income of relevant household members of the applicant's household, applying the relevant income modifications.

STEP THREE: Compare total household income to the FPL for the number of people in their household.

The following reviews, at a high level, some of the most important things to know in each of the steps when calculating MAGI household income eligibility

It is important to note that MAGI household and income calculations are complicated and individuals certified by Covered California to provide enrollment assistance should either

reference the calculator or call the Service Center at 1.888.975.1142 for assistance when helping consumers apply for an eligibility determination.

STEP ONE: Identify the members of the applicant's family

When a family applies for health coverage, applicants will answer a series of questions about themselves and about other individuals in their family who are applying for coverage.

Based on the responses to the application questions we will know:

- the familial relationships between different members of the family (e.g., whether they are spouses, parents, children); and
- the tax relationships between different members of the family (e.g., whether they are tax filers or tax dependents).

When assessing Medi-Cal eligibility, the online application also determines whether the household:

- plans to file a federal income tax return in the year they will receive coverage; OR
- does not intend to file a federal income tax return in the year they will receive coverage.

Depending on the answers the applicant provides, a different set of household rules will be applied. Once those rules are applied, the online application will compose the household and turn to **STEP TWO** for determining household income.

STEP TWO: Add the income of relevant household members

A household's current monthly income is used to evaluate eligibility for Medi-Cal. Individuals are asked on the single, streamlined application what their income is in the month they are applying.

The online application will apply an IRS measure of MAGI which defines what counts as income after selected deductions are taken into account.

MAGI consist of four types of income that are counted in determining eligibility:

- Adjusted gross income
- Social Security benefits are not included in adjusted gross income
- Tax-exempt interest
- Foreign earned income

There are some additional modifications to MAGI that must be made when determining Medi-Cal eligibility. These modifications do not apply when the online application determines eligibility for a Covered California health plan subsidy:

- Lump sum payments (i.e., gifts, prizes, income and property tax refunds) are counted only in the month received
- Educational scholarships, awards or fellowships used for education purposes are excluded from consideration as income;
- Certain types of income for American Indian/Alaska Native individuals are excluded.

STEP THREE: Compare Total Household Income to the Federal Poverty Level

The following chart highlights the 2014 Medi-Cal income eligibility thresholds for different populations

Medi-Cal Eligible Populations	Income Eligibility Thresholds
Children	Up to 250% FPL
Pregnant Women	Up to 200% FPL 300% FPL (non-Medi-Cal coverage also available for pregnant women)
Adults	Up to 138% FPL
Foster children	No income requirements apply. Former foster children up to age 26 are eligible if they were enrolled and were in foster care at age 18.

3.1.6 Non-MAGI Eligibility

Some people will qualify for other types of Medi-Cal programs based on eligibility rules that are different from MAGI including those:

- 65 or older
- Blind
- Disabled
- In a skilled nursing or intermediate-care home
- On refugee status for a limited time, depending on how long they have been in the United States
- People in Medicare Savings Program
- Being screened or have been screened for breast and/or cervical cancer, the Breast and Cervical Cancer Treatment Program (BCCTP)
- Supplemental Security Income/State Supplementary Payment (SSI/SSP)
- California Work Opportunity and Responsibility to Kids (CalWorks)
- Refugee Assistance
- Foster care or adoption assistance program

3.1.7 Medi-Cal Term of Eligibility

An applicant's Medi-Cal effective date is the date of the application submission. An individual or family can keep Medi-Cal coverage for as long as they continue to meet the eligibility requirements.

3.1.8 Medi-Cal Eligibility and Premium Assistance

People who are eligible for Medi-Cal are not eligible for Covered California with premium assistance. However, when the online application determines that an applicant is not eligible for Medi-Cal, or at any point during the application process, the applicant can choose to request a full Medi-Cal determination by the California Department of Health Care Services on a basis other than MAGI(non-MAGI). In some instances, the coverage available on a non-MAGI basis might better fit an individual's health care needs.

While that is happening, the applicant can enroll temporarily in a Covered California Health Plan and use any premium assistance and cost-sharing reductions if their attested information qualifies them. It is important to know that if it turns out they are not eligible they must re-pay the premium amount up to a certain dollar amount. (The maximum premium amount is based on income is $600 for individuals with incomes below 200% of the FPL; $1500 for individuals with incomes between 200% and 300% of the FPL; and $2500 for individuals with incomes between 300% and 400% of the FPL.) If the Department of Health Care Services determines that the applicant is eligible for any Medi-Cal, then he or she would dis-enroll from the Covered California Health Plan and enroll in Medi-Cal.

4 Lesson 3: Eligibility to Purchase Covered California Products, Full Cost or With Premium assistance

In this lesson you will learn more about premium assistance options available through Covered California, as well as how to determine eligibility for these options.

4.1 Learning Objectives

By the end of this lesson, you will be able to:

- ✓ Determine eligibility to purchase Covered California products
- ✓ Determine eligibility for premium assistance to purchase Covered California products
- ✓ Describe examples and use of premium assistance
- ✓ Determine eligibility for Cost-Sharing Reductions
- ✓ Verify eligibility for Medi-Cal or Covered California Products
- ✓ Understand the steps needed to resolve inconsistencies

4.1.1 Determining Eligibility to purchase Covered California Products

Any eligible Californian can enroll in health insurance through Medi-Cal or Covered California, regardless of their household income or whether they already have existing health coverage. All that is required for eligibility is that consumers be:

- A California resident (or they intend to reside in California); and
- A U.S. citizen, a national or lawfully present in the U.S; and
- Not incarcerated.

California Residency

In order to be eligible for a Covered California Product the applicant must reside, or intend to reside, in California. Applicants will attest to their address on the single streamlined application and the online application will accept that attestation as part of the verification process.

Citizenship and Immigration Status

To be eligible for a Covered California Health Plan, either with premium assistance or without, an individual must be a U.S. citizen, national or lawfully present.

An individual is lawfully present if they are a "qualified" immigrant or are not a citizen but have permission to live and/or work in the U.S. Individuals who are lawfully present include, but are not limited to:

- Lawful permanent residents
- Refugees who are seeking Asylum
- Individuals paroled into the U.S. for humanitarian or public interest reasons
- Individual for whom deportation is being withheld
- Individuals granted conditional entry
- Individuals with temporary protected status from countries designated by the U.S. Department of Homeland Security as unsafe to accept their return
- Cuban and Haitain individuals paroled into the U.S.
- Individuals who have been battered or subjected to extreme cruelty and certain household members

This is not an exhaustive list but an example of the most common immigration statuses. To see the legal requirements for who qualifies as "lawfully present" including the definition of "qualified immigrants" go to:

- http://www.law.cornell.edu/cfr/text/45/152.2
- http://www.law.cornell.edu/uscode/text/8/1641.

Another helpful resource is the following report, "Lawfully Present Individuals Eligible under the Affordable Care Act," by the National Immigration Law Center (September 2012). Available at: www.nilc.org/document.html?id=809.

Citizens who do have appropriate immigration status for Covered California products, may still qualify for some Medi-Cal programs if they are within the income limits.

Not Incarcerated

Applicants are ineligible for a Covered California product if they are incarcerated post-disposition. Individuals who are awaiting the disposition of their charges are eligible. For example, an individual who was arrested and is awaiting their trial is eligible for a Covered California Health Plan.

Residency, citizenship/immigration status and incarceration are factors that all apply when determining eligibility for Covered California products, with or without premium assistance.

4.1.2 INCOME ELIGIBILITY

Once an individual meets the criteria for eligibility to purchase Covered California products, the next step is determining eligibility for premium assistance. Similar to the household income eligibility process laid out in the Medi-Cal section, premium assistance for a Covered California Plan is based on the following three step process with a few key differences highlighted below.

STEP ONE: Identify the members of the applicant's family who are considered part of his or her household for MAGI purposes.

- Unlike eligibility for Medi-Cal, applicants seeking premium assistance must intend to file taxes or be claimed as a tax dependent in the coverage year.
- Married couples must file jointly if they seek premium assistance for a Covered California product.

STEP TWO: Add the income of relevant household members of the applicant's household.

- Similar to Medi-Cal, eligibility is based on the IRS definition of MAGI.
- The Medi-Cal exceptions such as lump-sum payments and educational awards are not applied when determining eligibility for Covered California premium assistance.

STEP THREE: Compare total household income to the Federal Poverty Level for the number of people in their household.

- To be eligible for premium assistance the household income must be between 100% and 400% of the FPL.
- Lawfully present immigrants with incomes below 100% of the FPL are eligible for premium assistance if they are ineligible for Medi-Cal because of their immigration status.

4.1.3 Minimum Essential Coverage (MEC)

Some consumers are not eligible for premium assistance if they have access to other government (e.g., Medi-Cal or Medicare) or employer sponsored "Minimum Essential Coverage" (MEC) that is either affordable or offers minimum value.

- Employer sponsored coverage affordability: Is considered affordable if the employee's share of the annual premium for self-only coverage is no greater than 9.5% of annual household income.
- Affordability: A plan is considered affordable if the person is required to contribute 8% of their income or less towards the plan. An individual will not be required to pay the penalty for not having insurance if the health insurance premiums in the plans offered by Covered California exceed 8% of their family/household income.
- Minimum Value: Job-based coverage provides minimum value if it pays for 60% of the benefits covered by the plan. Individuals must pay no more than 40%.

These exceptions mean that the employer-sponsored or agreement insurance is considered not comprehensive or unaffordable. They are therefore eligible to receive premium assistance to reduce the cost of coverage purchased through the Exchange. To use premium assistance, consumers must enroll in a health plan through Covered California.

4.1.4 Using Premium Assistance

Below are examples of how premium assistance makes health insurance coverage more affordable for Californians with low and middle incomes.

These are examples. Actual costs and the amount premium assistance vary depending on each consumer's specific situation.

	Health Care Premium	Premium Assistance	Premium after Assistance
Joan is a 40-year-old single mother with three kids. **She earns about $35,000 per year.**	Joan's health insurance premium could be as much as $12,336 per year.	Under the Affordable Care Act, Joan qualifies for $10,908 in premium assistance.	Joan pays $1,428 per year after applying the premium assistance for a Silver plan. Her monthly payment is about $119.
Henry and June are married with two children. **They earn about $50,000 per year.**	Like Joan, Henry and June's total health insurance premium is about $12,336 a year.	With their income, Henry and June qualify for a premium assistance of $8,892.	The premium assistance brings the annual premium for a Silver plan down to $3,444 or $287 a month.
Tory is 22 and unmarried. **She earns about $18,000 each year. Her parents do NOT claim her as a dependent on their tax returns.**	Tory's annual health insurance premium is about $3,408.	Tory qualifies for $2,607 in premium assistance.	Her annual premium is now $816, or about $68 each month.
Jacob is a 24 year old college student whose part time job results in income of $12,000 each year. His parents claim him on their tax returns.	Because Jacob's parents claim him as a tax dependent Jacob's annual health insurance premium will be determined by his parent's household income. Jacob can obtain coverage as a dependent on his parents plan until turning 26.	Because Jacob's parents claim him as a tax dependent Jacob's premium assistance is determined by his parent's household income.	Jacob's annual premium after premium assistance will be determined by his parent's household income.
Dustin and Blair are a same sex couple who have lived together for 7 years, but file taxes separately. Neither Dustin nor Blair can claim the other as a dependent. Dustin earns $50,000 per year. Blair earns $30,000 per year. Both are 40 years old.	Dustin and Blair will each pay an annual health insurance premium of approximately $3,500 a year for the silver plan.	Dustin's income makes him ineligible for premium assistance. Blair qualifies for $1,020 in annual premium assistance.	Dustin's annual premium is $3,500 or $294 per month. Blair's annual premium assistance reduces his annual premium to $2,508 or $209 per month.

Because of their income level, Joan and Tory may also be eligible for Cost Sharing Reductions (CSRs) to help lower their expenses when they use health care services (e.g. co-pays). Consumers who are eligible for premium assistance can choose when and how they want to apply their premium assistance amount. Once again, premium assistance can only be used with the purchase of a Covered California Health Plan.

Here are the options:

1. Take the premium assistance in advance to lower the cost of monthly premiums;
2. Apply the premium assistance at the end of the year when filing taxes;
3. Use some of the premium assistance in advance and receive the balance at tax time;
4. Change the portion applied in advance at any time.

Let's look at some examples:

Sam is eligible for $700 in premium assistance based on his income. He enrolls in a Covered California Health Plan with a January 1st, 2014 effective date.

Sam decides to apply the full $700 right away. Covered California notifies Sam's health insurance company and they apply the premium assistance amount as a credit to the premium bills they send to Sam.

At the end of the year, Sam reports the $700 premium assistance on his tax return.

Greta also is eligible for $700 in premium assistance and, like Sam, enrolls in a Covered California Health Plan with a January 1st, 2014 effective date.

She thinks she might get a raise in 2014 and knows that could change the amount of her premium assistance. She decides to be conservative and applies just $300 of her premium assistance.

Later in the year, she decides she wants to change the amount applied in advance to $500. She calls the Covered California Service Center to make the change. Covered California updates Greta's health insurance company, and they show the difference on her remaining monthly premium bills.

At the end of the year, Greta reports the $500 premium assistance on her tax return.

Income changes during the year can increase or decrease premium assistance.

- If income goes up, the premium assistance will go down. If Sam's income goes up in 2014 and he does not report the change when it occurs, he may have to pay more in taxes at the end of the year.

  That's because he won't get the $700 he was eligible for when his income was lower but he applied the full $700 to his premiums. He will be responsible for any difference in the taxes he owes when he files his taxes.

- If income goes down, the premium assistance goes up. Let's say Sam had a pay cut in 2014. Instead of $700 of premium assistance, his new income qualifies him for $1,000 of premium assistance. At the end of the year, IRS will calculate the premium assistance amount based on the income information received to date and information on the months in which Sam purchased his Covered California plan.

Important to tell consumers!

1. **Report income changes right away**. We do not want consumers to be surprised at tax time. That is why it is very important that they report any income changes immediately to Covered California. They can do that via the online application or by calling the Covered California Service Center.
2. **Married couples who qualify for premium assistance must file a joint return** to apply the premium assistance amount as a credit to their taxes.

Important! In some areas, premium rates are so low that the premium assistance tops out below 400 percent of FPL. This happens when the premium is less than 8 percent of a consumer's annual household income.

Example: Sally is a 21-year-old and her annual income is $39,000. That puts her at 335 percent of FPL. She wants to buy a silver plan. Let's say her health insurance premium for 2014 will be $3,018 for the silver plan. That amount is equal to 7.74 percent of her household income. Since that percent is less than the 9.5 percent maximum, Sally would not receive premium assistance. She could, however, still buy health insurance through Covered California.

Good to Know

You may see or have a consumer ask about these terms:

- Advance Payment of the Premium Tax Credit (also APTC)
- Cost sharing reductions (also subsidies, cost sharing subsidies, CSR)

Covered California is using the phrases "premium assistance" and "cost-sharing reductions" because the terms have been tested with consumers and found to be more meaningful and understandable. Cost-sharing reductions translate to improved benefits.

4.1.5 What are Cost-Sharing Reductions?

After payment of premium and plan enrollment, cost-sharing reductions (CSR) help people with their out-of-pocket costs like deductibles, coinsurance and co-pays.

- Only available to people who enroll in a silver plan which are referred to as "Enhanced Silver Plans" when they include CSR.
- There are three levels of savings available to people who qualify for a CSR.
- The level of savings (or tier) for which a family qualifies is based on the family's income.
- The issuers provide the extra help with out-of-pocket costs by offering a silver plan with higher actuarial value.
- The higher the actuarial value, the lower the deductibles, coinsurance, and/or copayments.

The Charts below show the tiers of cost-sharing reductions:

CSR Tier	Income Range	Actuarial Value of the Silver Plan
1	Special populations < 100% FPL; 100% FPL – 150 %FPL	94%
2	150% FPL - 200% FPL	87%
3	200% FPL – 250% FPL	73%

Silver plan variations offered in these levels.

IF SHE QUALIFIES FOR……..	TIER 1 CSR Silver Plan: 94% Actuarial Value	TIER 2 CSR Silver Plan: 87% Actuarial Value	TIER 3 CSR Silver Plan: 73% Actuarial Value	NO CSR Silver Plan: 70% Actuarial Value
	<150 %FPL	**150% FPL - 200% FPL**	**200% FPL - 250% FPL**	**250% FPL - 300% FPL**
	Up to $17,235	**$17,236 - $22,980**	**$22,981 - $28,725**	**$28,726 – $45, 960**
Primary Care Visit	$3	$15	$40	$45
Specialist Visit	$5	$20	$50	$65
Laboratory Tests	$3	$15	$40	$45
X-Rays and Diagnostics	$5	$20	$50	$65
Generic Drugs	$3	$5	$19	$19

4.1.6 Determining Eligibility for Cost Sharing Reductions (CSR)

Consumers with income up to 250 percent of FPL receive both premium assistance and cost-sharing reductions. The premium assistance credit is based on the second-lowest cost Silver plan. To receive a cost-sharing reduction the individual must be enrolled in any Silver plan.

With the addition of cost-sharing reductions the percentage of covered expenses goes up. In essence, the benefit coverage becomes more comprehensive. The row titled, "eligible for improved benefits" in the chart below illustrates how this works:

Income Ranges Related to FPL								
	100%	**150%**	**150%**	**200%**	**200%**	**250%**	**250%**	**400%**
Individual	$11,490	$17,235	$17,235	$22,980	$22,980	$28,725	$28,725	$45,960
2 in family	$15,510	$23,265	$23,265	$31,020	$31,020	$38,775	$38,775	$62,040
3 in family	$19,530	$29,295	$29,295	$39,060	$39,060	$48,825	$48,825	$78,120
4 in family	$23,550	$35,325	$35,325	$47,100	$47,100	$58,875	$58,875	$94,200
% of income consumer pays in premiums to enroll in coverage	2-4%		4-6%		6-8%		8-9.5%	
Eligible for improved benefits	Yes 94% coverage		Yes 87% coverage		Yes 73% coverage		No — standard 70% coverage	

Consumers who get CSR pay less out-of-pocket when they use health care services. For example, if Jane qualifies and enrolls in a 94 percent Silver plan she pays $3 for a primary care visit. She would pay $45 for a primary care visit if she were not eligible for CSR.

Coverage Category	**94% Silver**	**87% Silver**	**73% Silver**	**70% Silver**
Eligibility based on Income Ranges and Associated Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost	Covers **70%** average annual cost
Income Ranges	**100% - 150% FPL**	**150% - 200% FPL**	**200% - 250% FPL**	**250% - 400% FPL**
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$3	$15	$40	$45
Specialist Visit	$5	$20	$50	$65
Laboratory Tests	$3	$15	$40	$45
X-Rays and Diagnostics	$5	$20	$50	$65
Imaging	10%	15%	20%	$250

Coverage Category	94% Silver	87% Silver	73% Silver	70% Silver
Eligibility based on Income Ranges and Associated Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost	Covers **70%** average annual cost
Generic Drugs	$3	$3	$19	$19
Annual Out of Pocket Maximum Individual and Family	$2,250 Individual and $4,500 Family	$2,250 Individual and $4,500 Family	$2,250 Individual and $10,400 Family	$6,350 Individual and $12,700 Family

4.1.7 Verifying Eligibility for Medi-Cal or Covered California Products

Once the applicant has provided their information and the application has been submitted Covered California proceeds to verify eligibility to evaluate whether the person may enroll in Medi-Cal or purchase a Covered California health plan with or without premium assistance.

4.1.8 Minimum Essential Coverage

Covered California verifies whether an applicant is eligible for MEC. This verification applies only to Covered California health plans with premium assistance. MEC is not an eligibility factor for Medi-Cal or for Covered California health plans at full cost.

- Covered California verifies whether the individual has already been determined eligible for coverage through Medi-Cal or TLICP using information obtained from the Department of Health Care Services. Covered California will receive information about whether the applicant is offered MEC as a federal employee or a veteran from the Department of Health and Human Services via the Federal Data Services Hub (DSH)
- Covered California, through the application process, will provide a worksheet to consumers to help them understand if their current employer sponsored insurance offers MEC. If the employer sponsored insurance is deemed both affordable and provides minimum value the applicant will be found ineligible for a Covered California health plan with premium assistance. The applicant may qualify for a Covered CA health plan without premium assistance.

4.1.9 Household Income and Size

Covered California will verify household size and MAGI income using both tax return data and current state data sources.

- Covered California gets IRS tax return data from the Secretary of the Treasury via the Department of Health and Human Services federal hub to verify attestation of income.
- Covered California will also use current data sources. When verifying an applicant's attestation of income for determining Medi-Cal eligibility, Covered California will use a combination of both IRS data and current data sources. If the IRS data is not available or the attestation is not reasonably compatible with the IRS data, Covered California will review current data sources.

4.1.10 Citizenship and Immigration Status

Covered California will verify an applicant's attestation of citizenship using available data from the Social Security Administration and the Department of Homeland Security.

4.1.11 Premium Assistance and Cost-Sharing Reductions (CSR)

Consumers have to reconcile any advance premium assistance and CSR at the end of the year when they file their tax return. Since any amounts they received during the benefit year are based on their income, changes to income can change their premium assistance and CSR.

It is very important that consumers understand their responsibility related to premium assistance and CSR. Consumers will need to attest that the information they provided on their application is accurate and true in order to be eligible for premium assistance.

Listed below is a summary of the eligibility factors that must be verified and what data bases are used to verify them.

Eligibility Factor	Data Base Used to Verify Eligibility or Attestation Accepted
Social Security Number	Social Security Administration
Citizenship	Social Security Administration and Department of Homeland Security
Immigration Status	Department of Homeland Security
Residency	Attestation accepted unless the information doesn't match other information available to Covered California.
Incarceration Status	Attestation accepted as provided in the application unless the information doesn't match other information available to Covered California.
Income	Department of Treasury Current data sources (eg. IRS)
Minimum Essential Coverage (MEC)	Department of Health and Human Services Department of Health Care Services

Covered California applies a "reasonably compatible" standard to any differences or discrepancies between the application and the verification data sources. This means that slight differences won't impact an applicant's eligibility. If however, the applicant's attestation is not reasonably compatible with available information or data, then Covered California will follow a process to resolve inconsistencies.

4.1.12 Resolving Inconsistencies

Covered California has a process in place to resolve inconsistencies and when information cannot be verified and is not reasonably compatible. The steps of this process are:

Step 1: Covered California first tries to identify and address the cause of the inconsistency by requesting a reasonable explanation from the applicant. If the applicant provides a reasonable explanation for the discrepancy between the data sources and their attestation, the person's eligibility is determined based

on the information they provided. For example, an individual may explain that they recently lost their job and have no income. This may be considered a reasonable explanation for why the IRS data and the current data sources show the individual making income above the Medi-Cal eligibility levels. If the applicant is unable to provide a reasonable explanation, Step 2 happens.

Step 2: Covered California notifies the applicant about the inconsistency between the data and their attestation and requests satisfactory documents for verification. For example:

- If an individual attests to their income and Covered California was unable to verify the attestation against IRS or current data sources, the individual may be required to provide their most recent pay stubs.
- If an individual attests to their immigration status as a lawful permanent resident but Covered California is unable to verify using federal data from the Department of Homeland Security the applicant may have to provide a copy of their Green Card.

Step2a: The applicant has 90 days from the date of the notice to resolve the inconsistency. This can be done by providing documentation. If applicants need more time, they can request an extension as detailed in the next section.

Step 2b: During the 90 days, Covered California proceeds with all other elements of eligibility determination for the applicant and may provide temporary coverage for Covered California premium assistance. This includes making sure that any advance payments of the premium assistance and cost-sharing reductions are provided on behalf of an applicant. Applicants have to attest that they understand that any payments made on their behalf have to be reconciled at the end of the year when they file their tax return. Medi-Cal only provides temporary coverage if the applicant is reconciling a discrepancy based on citizenship or immigration status.

Step 3: If, after Step 2, Covered California remains unable to verify the information, the applicant's eligibility for Covered California premium assistance will be determined based on the information contained in the databases that were used to verify the information reported by the consumer on their application. For Medi-Cal certain eligibility elements that cannot be verified will stop eligibility for Medi-Cal and the county must follow up with the consumer. If the application is not received, the application is denied.

Covered California has to make this determination no earlier than 10 days after and no later than 30 days after the date it sent the notice to the applicant in Step 2.

4.1.13 Requesting an Extension

Consumers who need more time to resolve application inconsistencies can request an extension. The process works like this:

- The consumer contacts Covered California with the reason explaining why he or she needs more time.
- Covered California reviews the request. The decision is sent to the consumer.
    - An example of when an extension may be granted is where the consumer demonstrates due diligence in trying to obtain documentation to resolve an

inconsistency. For example, he or she provides a copy (photocopy of a letter or copy of an email) of the request made to the agency that can provide the documentation.

- Photocopy of Letter to/from agency
- Copy of e-mail submission

- For approved extensions, Covered California will follow up with the consumer by phone or written notice within 30 days from the date of approval.
- The consumer has 30 days from the date of the reminder notice to respond.
- If the consumer responds to the reminder and provides additional information explaining why he/she still cannot provide the documents, Covered California will determine if he/she continues to qualify for the extension.
- Covered California will send written notification about the decision to the consumer.

Medi-Cal has a process in place based on "good cause" and counties work with the consumer on a case-by-case basis on extension timing and scope.

4.1.14 Case-by-Case Exceptions

On a case-by-case basis, Covered California may accept an applicant's attestation as to the information which cannot be verified and the applicant's explanation of the circumstances why he or she does not have the documentation if:

- An applicant does not have documentation with which to resolve the inconsistency through this process because the documentation doesn't exist or is not reasonably available;
- Covered California is unable to otherwise resolve the inconsistency for the applicant; and
- The inconsistency is not related to citizenship or immigration status.
- As a last resort the consumer can sign a statement under penalty of perjury.

5 Lesson 4: Purchasing Covered California Products as an American Indian and Alaska Native

5.1 Learning Objectives

By the end of this lesson, you will be able to:

- ✓ Describe special eligibility standards for American Indians and Alaska Natives
- ✓ Determine Eligibility for Cost-Sharing Reductions
- ✓ Understand enrollment periods and verification of status

5.1.1 Overview of Purchasing Covered California Products as an American Indian and Alaska Native

There are special eligibility standards for American Indians and Alaska Natives under the Affordable Care Act. The Indian Health Care Improvement Act includes Native Americans and Alaska Natives in its definition. The term applies to any individual who:

- Is a member of a federally-recognized tribe by the United States Bureau of Indian Affairs (BIA) in the U.S. Department of the Interior.
- First or second descendants of tribe members as described in the point above.
- An Eskimo or Aleut or other Alaska Native.
- Is considered by the Secretary of the Interior to be an Indian for any purpose.
- Is determined to be an Indian by the Secretary of Health, Education and Welfare in collaboration with the Department of Health and Human Services.

5.1.2 Eligibility for Cost-Sharing Reductions

American Indians and Alaska Natives (and others as defined above) do not have to pay co-pays or cost-sharing if they:

- Expect to have a household income that does not exceed 300 percent of FPL for the benefit year for which coverage is requested;[iii] and
- Enroll in a Covered California Health Plan.

If enrolled in a Covered California Health Plan, any cost sharing is eliminated if a service is provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contracted health services.

5.1.3 Exemption from Individual Mandate Penalties

American Indians and Alaska Natives are exempt from Individual Mandate penalties.

5.1.4 Enrollment Periods

American Indians and Alaska Natives may enroll outside of Open Enrollment periods and may change their coverage once a month.

5.1.5 Verification of Status

If an applicant attests that he or she is an American Indian or Alaska Native (or others as defined above), Covered California must verify status by verifying the attestation against available data sources.

Covered California uses the information provided by the applicant to make a decision about eligibility. The applicant has 90 days to provide documentation.

6 Lesson 5: Eligibility for Referrals, Appeals and Redetermination

This lesson covers the process in which Covered California will refer consumers to other health programs, the appeals process and the redetermination process.

6.1 Learning Objectives

By the end of this lesson, you will be able to:

- ✓ Describe referrals to non-Covered California Health Programs
- ✓ Describe the appeals process
- ✓ Determine Eligibility Redetermination

6.1.1 Referrals to non-Covered California Health Programs

The online application also supports referrals to non-Covered California health programs. The application asks, "Would anyone in the household like a referral to the local Health and Human Services Agency for any of the following programs: CalWorks or CalFresh?"

Consumers who answer yes will be provided the contact information for the nearest agency. The application will be referred and forwarded to CalWorks/CalFresh and they will follow-up with the consumer to obtain additional information and help them apply for benefits. This is also the case when the consumer wants a non-MAGI referral.

6.1.2 Consumer Appeals Process

Covered California has an appeals process for consumers who disagree with any of the following:

- Eligibility determination for Medi-Cal or Covered California Health Plan
- Determination of the amount of the premium assistance or CSR
- Annual redetermination of eligibility
- Eligibility determination for an exemption to the requirement to have health insurance related to claims based on hardship, religious beliefs, being a member of the ministry, incarceration or being an American Indian or Alaska Native.

The process works like this:

1. Consumers have 90 calendar days from the notice date of the determination to submit an appeal.
2. Covered California has 90 calendar days (pending Federal rule making) from the date the appeal is submitted to study and settle the appeal. The 90 day timeframe is dependent on federal regulators providing a response to Covered California. During this time, Covered California will
    - Work closely with the consumer to resolve the issue informally
    - Hold a formal hearing process to settle the appeal if the appeal is not resolved informally
3. Consumers who are not happy with the appeal hearing decision related to premium assistance or CSR can appeal directly to the U.S. Department of Health and Human Services.

6.1.3 Complaints or Concerns

Covered California is committed to supporting consumers, and invites all Californians to call the Covered California Service Center with any complaints or concerns.

There are a number of other California state resources available to support consumers.

The Office of Patient Advocate: This state agency provides a great overview of the health care industry, with a glossary of terms, patient rights, and a step-by-step guide that shows consumers how to deal with a problem or file a complaint against their health care insurance company. This agency does not file complaints against health insurance providers, but it can tell consumers what state agencies can help. The agency's website is www.opa.ca.gov. The agency's phone number is 1.866.466.8900.

California Department of Managed Health Care (DMHC): This state agency oversees HMOs and some PPOs. Consumers can contact the DMHC if they have filed a complaint against their health insurance company because it denied coverage based on lack of medical necessity or a treatment being considered experimental or investigational in nature. This agency administers what is called an "Independent Medical Review." If their situation qualifies, an independent physician will review the health insurance company's decision and has the power to overturn that decision. The IMR is a free service available to anyone in California enrolled in a managed care health plan. This agency has the power to file a "standard complaint" against a health insurance company about a coverage denial and can overturn the company's decision. The agency's web site is www.dmhc.ca.gov. The agency's phone number is 1.888.466.2219.

California Department of Insurance (CDI): This state agency handles complaints against PPOs and it functions just like the Department of Managed Health Care. Consumers can file a complaint with the DOI against their PPO if coverage was denied based on lack of medical necessity or if a treatment being considered experimental or investigational in nature. This agency administers what's called an "Independent Medical Review." If their situation qualifies, an independent physician will review the health insurance company's decision and has the power to overturn that decision. The IMR is a free service available to anyone in California enrolled in a managed care health plan. This agency has the power to file a "standard complaint" against a health insurance company about a coverage denial and can overturn the company's decision The agency's web site is www.insurance.ca.gov. The agency's phone number is 1.800.927.4357.

Medi-Cal: Consumers who have regular (fee-for-service) Medi-Cal and have a complaint may contact their local county office for help. For a complete listing of offices and phone numbers, contact the **Department of Health Care Services**, www.dhcs.ca.gov or call 916.445.4171. Consumers in a Medi-Cal Managed Care Plan may contact either the **Medi-Cal Managed Care Ombudsman**, 1.888.452.8609, or the **Department of Managed Health Care**, 1.888.466.2219.

6.1.4 Eligibility Redetermination

One of Covered California's jobs is to confirm consumer eligibility from time to time. There are two processes: 1) semi-annual data matching; and 2) annual redetermination.

6.1.5 Data Matching

Data matching helps Covered California determine whether or not the consumer continues to qualify for coverage during the benefit year. This process occurs semi-annually and checks for three things:

1. Whether or not the consumer is deceased
2. Whether or not the consumer had a recent eligibility determination which resulted in enrollment into Medicare or Medi-Cal
3. Whether household income changes by more than 10 percent

The goal in checking household income is three-fold:

- Educate consumers about any potential changes to their eligibility for premium assistance or cost-sharing reductions as a result of an income change;

- Enable consumers to adjust their advance premium assistance accordingly to help minimize repayment of taking excess advance premium assistance taken during the benefit year; and
- Increase consumer ability to obtain more affordable coverage when income goes down.

A three-step process happens when data matching shows a difference in the consumer's income than what was originally used to determine eligibility:

1. Covered California sends a notice to the consumer that lists the new income information and the enrollee's projected eligibility.
2. The consumer has 30 days to respond to the notice.
3. If the consumer does not respond, he or she may keep his or her Covered California eligibility and premium assistance based on the original information.

However, the consumer will have to confirm their eligibility during the annual eligibility redetermination process. He or she also will have to reconcile the premium assistance amount when filing taxes at the end of the year.

6.1.6 Annual Redetermination

All individuals enrolled in a Covered California Health Plan go through an annual eligibility redetermination process during open enrollment. Medi-Cal eligibility is re-determined on an annual basis. Because this process happens after initial enrollment, we discuss it in detail in the Post Enrollment course.

7 Lesson 6: Consumer Responsibilities

Changes in income, employment, marital status, household, and other factors may impact eligibility. For example, a change in income can impact eligibility for amount of cost-sharing reductions.

7.1 Learning Objectives

By the end of this lesson, you will be able to:

- ✓ Understand required self-reporting
- ✓ Understand recommended self-reporting

7.1.1 Required Self-Reporting

Consumers are required to self-report changes to Covered California within 30 calendar days from the date of a change if any of these things happen:

- Add a household member (birth, adoption, marriage, etc.)
- Remove a household member
- Change in incarceration status
- Change in health coverage
- Change in citizenship/immigration
- Change in income (employment)
- Change in income (self-employment)
- Change in income (other)
- Change in income (income tax deductions)
- Miscellaneous information change

status

- Change in household contact information change
- Change in name
- Tax information change
- Change in all income type and deductions (newly eligible/ineligible for APTC)

Consumers can report these changes via the online application or by calling the Covered California Service Center at 888.975.1142.

If a consumer has Medi-Cal they are required to report a change within 10 days from the date of change.

7.1.2 Recommended Self-Reporting

Consumers can become eligible for special enrollment in a Covered California health plan through Covered California. This is the time outside of the open enrollment period when qualified individuals can sign up for health insurance.

Consumers have 60 calendar days from the date of the qualifying event to take advantage of the special enrollment period. To start the process, they can use CalHEERS or call the Covered California service center.

Consumers who have a change in number of dependents can apply during special enrollment between the first and the fifteenth day of any month. Covered California must ensure a coverage effective date of the first day of the following month. If between the sixteenth and last day of any month, Covered California must ensure a coverage effective date of the first day of the second following month.

Covered California must ensure that coverage is effective on the date of birth, adoption, or placement for adoption, but advance payments of the premium assistance and CSR if applicable, are not effective until the first day of the following month unless the dependent number change happened on the first day of the month.

In the case of marriage, or in the case where a qualified individual loses MEC, the Covered California must ensure coverage is effective on the first day of the following month.

8 Activity and Answers

Test Your Knowledge
Income changes during the year can increase or decrease premium assistance. Which of the following scenarios is not true?

1. Take the premium assistance in advance to lower the cost of monthly premiums
2. Apply the premium assistance at the end of the year when filing taxes
3. Use some of the premium assistance in advance and receive the balance at tax time
4. Take the premium assistance in advance and place it in a savings account until the end of the year

Answer: 4.

9 ENDNOTES

[i] Code of Federal Regulations, Part 155 — Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act [45 CFR 155], § 155.410.

[ii] Ibid.

[iii] Code of Federal Regulations, Part 155 — Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act [45 CFR 155], § 155.350 (a)(ii)

Sources:

- MedlinePlus, a service of the U.S. National Library of Medicine, National Institutes of Health. Accessed at www.nim.nih.gov
- www.dhcs.ca.gov for Medi-Cal benefits